Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
517 NORTH CARRIER PARKWAY SUITE G
GRAND PRARIE TX 75050

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2054-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre-authorized - #8382468." "Pre-authorized - #8929795".

Amount in Dispute: $3700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, through mutual agreement with Texas Mutual, received preauthorization for two weeks of a pain management program at four hours a day." "The requestor provided eight hour per day sessions. Texas Mutual paid four hours of treatment per each session, consistent with the terms of the authorization." "Therefore, no further payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2010 March 23, 2010 March 30, 2010 March 31, 2010 April 1, 2010 April 5, 2010	Chronic Pain Management – CPT code 97799-CP (8 hours x 6 dates = 48 hours)	$400.00/day	$0.00
March 25, 2010	Chronic Pain Management – CPT code 97799-CP (6 hours)	$300.00/day	$0.00
April 2, 2010	Chronic Pain Management – CPT code 97799-CP (4 hours)	$400.00/day	$0.00
May 26, 2010	Chronic Pain Management – CPT code 97799-CP (7 hours)	$700.00/day	$700.00
TOTAL		$3,700.00	$700.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 10, 2010
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-197-Precertification/authorization/notification absent.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 930-Pre-authorization required, reimbursement denied.

   Explanation of benefits dated May 20, 2010
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-197-Precertification/authorization/notification absent.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 930-Pre-authorization required, reimbursement denied.

   Explanation of benefits dated June 9, 2010
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-197-Precertification/authorization/notification absent.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 930-Pre-authorization required, reimbursement denied.

   Explanation of benefits dated August 2, 2010
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-197-Precertification/authorization/notification absent.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 930-Pre-authorization required, reimbursement denied.

   Explanation of benefits dated February 4, 2011
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-197-Precertification/authorization/notification absent.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 891-No additional payment after reconsideration.
   - 930-Pre-authorization required, reimbursement denied.

Issues

1. Did the requestor support position that the disputed chronic pain management program was preauthorized?
2. Is the requestor entitled to reimbursement for the chronic pain management program?

Findings

1. The requestor states in the position summary that "Pre-authorized - #8382468." "Pre-authorized - #8929795".

   28 Texas Administrative Code §134.600 (f) states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in

subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the:

(1) specific health care listed in subsection (p) or (q) of this section;
(2) number of specific health care treatments and the specific period of time requested to complete the treatments."

28 Texas Administrative Code §134.600 (p) states "Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

On February 23, 2010 the requestor obtained preauthorization for "4 hours per day for 5 days for two weeks" beginning on 2/24/10 through 3/24/10.

Per 28 Texas Administrative Code §134.600 (f)(2), the preauthorized time frame was February 24, 2010 through March 24, 2010. Therefore, only March 9, 2010 and March 23, 2010 are within the preauthorized time frame. A review of the EOBs supports the respondent's position that the requestor was paid for the preauthorized four hours on each date; therefore, additional reimbursement is not recommended.

Further review of the EOBs indicates that the respondent also paid for services that were not in the preauthorized timeframe: three hours on March 8, 2010; four hours on March 25, 2010, March 30, 2010, March 31, 2010, April 1, 2010, April 2, 2010, and April 5, 2010. Because these dates were not within the preauthorized timeframe, additional reimbursement is not recommended.

On May 2, 2010, the requestor obtained preauthorization approval for an additional "80 hours 5 days per week for 2 wks 97799" beginning on 5/3/10 through 6/3/10.

Per 28 Texas Administrative Code §134.600 (f)(2), the preauthorized time frame was May 3, 2010 through June 3, 2010. The requestor only listed May 26, 2010 that falls within the timeframe. Neither party to this dispute submitted documentation to support that the requestor had exceeded the number of hours preauthorized; therefore, reimbursement is recommended for May 26, 2010.

2. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs:

   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   >
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP for 7 hours on May 26, 2010. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the 7 hours billed is $700.00. The respondent paid $0.00. The difference between the MAR and amount paid is $700.00. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. The Division concludes that the requestor supported its position that reimbursement is due. As a result, the amount ordered is $700.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent

to remit to the requestor the amount of $700.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/2/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.